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ABSTRACT

Specific ways were investigated for using evaluative date generated from two consumer satisfaction surveys in two different mental health settings. The first survey, consisting of 225 randomly selected current consumers of mental health services from Rochester Mental Health Center in Rochester, New York, explored global satisfaction, structural features of the facility (e.g., parking, waiting room), general service (e.g., treatment by those other than therapist) and satisfaction with specific program changes. Results pinpointed specific problem areas, led to staff discussions about reasons for using medication with clients, and examined the relationships between staff and clients. Further consumer data based on termination questionnaires and other instruments completed by students of the University of Rochester Counseling Services were collected in the second survey. Results of this survey indicated that: (1) relative to other types of consumer-provider relationships in the general marketplace, the counseling service area is often viewed by students as the only alternative available, and thus students are not necessarily selecting services on the basis of cost or quality; (2) there is often no direct penalty to the provider if the consumer-student leaves treatment, which can easily lead to too little or too low a quality of service; and (3) given the lack of the usual built-in consumer safeguards, the client needs to be involved more directly in the evaluation of services. Comparisons between the two studies revealed that consumer surveys helped to: (1) focus staff concern for neglected areas of consumer experience; (2) create dialogue between staff and administrators for problem identification and solution; (3) provide data for budget and program changes; and (4) provide opportunity for feedback that allowed for personal assessment of service delivery. (Author)

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Consumer Satisfaction:
Its Role in the Evaluation of Mental Health Services

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A Brief History

Consumer satisfaction surveys, long an accepted form of feedback for industrial concerns, have in the past rarely been evident in the professional literature of pyschologists. Rosen and Zytowski (1977) noted the dearth of consumer surveys in counseling literature, citing only three published papers in the past ten years.

Margolis, et al (1977), in a recent article, noted that clients have usually been excluded as evaluators of mental health service. Clients' evaluations of their own treatment outcomes have been discounted because: (a) they may want to please their help-giver and be responding to demand characteristics -- the "halo" effect; (b) the psychoanalytic belief that the client's self-report too easily could represent a "flight to health" phenomenon, expressed as satisfaction, or an unresolved negative transference or resistance, expressed as dissatisfaction; (c) clients lack the necessary information on which to base judgments, being too influenced by impermanent or situational behavior changes.

Finally, they suggest that for a number of years the economic and social factors which led to expanding mental health services in the 1960's meant there was less need for administrators in either the university or the community sector to be overly concerned about "proving their worth." There was less administrative pressure for involving the

consumer in evaluation of services. The major source of control over their jobs is primarily their employer--not the consumer. This is in contrast with the private practice setting in which the role of the consumer is central to the professional's evaluation of services and directly relates to the income generated by the individual.

A further point is made by Marvit and Beck who note that frequently, the consumers who utilize public mental health services are individuals who not only have little sense of choice but may, in fact, be quite limited in their choice of services. This is certainly true on most college campuses where students have access to a limited number of professional mental health resources in a semi-encapsulated environment. Many of the people using community health and mental health services are limited by economic, geographic, and programmatic rules as to where they can shop for service. Thus, both providers and consumers are often aware that the service is the "only game in town" which is open. The potential danger of this situation is that both players--the professional and the consumer--devalue the importance of consumer feedback and evaluation of services.

The Rise in Consumerism in Mental Health

In recent years there has been an increase in the use of consumer surveys and, specifically, consumer satisfaction surveys by mental health organizations. Several forces have led to a rebalancing of efforts to involve the consumer in the evaluative process. The consumer has more

recently been involved in not only assessing his or her outcome as a result of treatment but also in assessing program effectiveness and institutional effectiveness.

The reasons for this rapid increase in the use of consumer surveys as well as other evaluative activities involving the consumer include

(a) a general increase in consumerism of all sorts in the United States, as noted by the development of consumer agencies at all levels of government.

(b) the specific introduction in federal legislation for all community mental health centers to include consumers in the evaluation process as well as measuring the acceptability of services to clients.

(c) an increase in alternatives for consumers in mental health services. There is an increase in the number of self-help groups and peer counseling programs both in the campus and community settings. Often fostered or sponsored by professionals, these programs open the marketplace to healthy competition. One result of this is to push professionals to both evaluate their programs through the use of consumer evaluation and to seek endorsements from consumers in the form of consumer satisfaction surveys and testimonials.

(d) a need for administrators of agencies in the face of budget cuts or re-allocations to document to decision-makers that the agency is operating effectively and efficiently. Mental health and counseling administrators are increasingly aware that other administrators are often more impressed by consumers' evaluations than they are by other forms of evaluation. This is especially so as more counseling services engage in indirect and mediated services, such as training and consultation with faculty and other student services personnel. The more unfamiliar or new the service is--whether direct or indirect--the more important consumer feedback and evaluation is to justify these new activities. This is especially so if these new activities are being done with resources which are no longer as available for traditionally accepted activities.

Finally, as noted earlier, given the lack of checks and balances (due to the limited choice of service), the use of consumer evaluation acts as a vehicle to further evaluate the quality of service. Based on this author's experiences in mental health settings, there is often a great deal of pressure to increase the numbers of people being seen, while at the same time there are also increased demands for new forms of service. There are few organizational rewards for either the service deliverer or manager built in for increasing quantity or quality of

service. The consumer evaluations may then also offer a way to view how changes impact on quality of care, at least as perceived by the consumer. It also offers a vehicle for staff and others to view quality of service.

Dimensions of Consumer Satisfaction

There are a variety of techniques available for assessing client satisfaction. Basically, all client satisfaction questionnaires attempt to measure self-report of various clinical and/or nonclinical aspects of a client's experience with the service. A conceptual/analytic framework for understanding potential areas of consumer feedback is provided in the work of Messer and associates. Messer (cited in Hagedorn, H. J. et al, 1976) has developed an "analytic framework (which) is provocative of more precise thinking about the dimensions of CMHC's service processes." It is generally adaptable to all mental health delivery systems. With particular reference to consumer feedback, it allows for a conceptual separation of areas of feedback into:

(a) awareness of services by consumers (of direct and indirect services) and by community gatekeepers of the service it offers, and the conditions for which these services are appropriate.

(b) acceptability of services--the predilection by consumers to use and to continue to use a service.

(c) accessibility of service--the ease of reaching the service and obtaining its services.

Each of these areas may be further subdivided. The consumer survey is particularly sensitive to questions of acceptability. Acceptability can be divided into the following four areas, as noted in Figure 1.

Insert Figure 1 about here

Each of these sub-areas can be assessed in consumer evaluation surveys. Also assessed by consumer evaluations is the area of accessibility--geographic; psychological; cultural; temporal (e.g., hours of operation, appointment times, time between request and first appointment); and financial.

Two Settings

Two studies, one done at a local community mental health center (CMHC) and the other a university counseling center (CC), measured consumers' responses with respect to issues of acceptability and accessibility. Both of these studies were attempts to collect information on consumer reaction to services, but were different from each other in a number of ways.

The CMHC study was designed with significant staff input and was an attempt to focus attention on several specific questions raised by staff and administrators--specifically, the impact on the consumer of subprograms on each other, e.g., the effect of the drug program in the same space as other general mental health programs; the reactions of participants to

both group and individual psychotherapy; and the effect of costs on accessibility. The CMHC, which was more expensive, was a telephone interview with a number of open-ended questions, as well as multiple-choice questions. Although there was some discussion about the usefulness of repeated surveys over time, there was no plan on how to repeat this survey or parts of it, following the initial random survey of 250 people.[1]

The University of Rochester studies, in contrast, have been repeated annually. They have been completed by 20 to 30 percent of the students receiving service. Cost is significantly less, with the questionnaire having multiple choice scales. Generally the data is less rich and less complex than the CMHC, especially for a given year. Table 1 summarizes these comparisons.

Insert Table 1 about here

Both of these studies share the major problem in the interpretation of all consumer satisfaction data. There is a striking tendency for consumer satisfaction studies to produce remarkably high overall levels of satisfaction. Linn (1975) notes with regard to health care in general, "overall levels of satisfaction are very high, irrespective of the method used, the population sampled, or the object of the rating." The following table (Table 2), which includes our results, illustrates this finding.

[1]Twenty-five of these 250 could not be reached by phone, and another 13 would not agree to the telephone interview. Two hundred twelve interviews were completed.

Insert Table 2 about here

Despite uniformly high satisfaction levels, there are a number of ways in which the data can be used effectively. First, comparisons of various subgroups of clients; second, comparisons of satisfaction level over time; third, identification of aspects of the service delivery system with which there is significant increase in expressed dissatisfaction; fourth, comparisons of consumer satisfaction with other parties' satisfaction.

For instance, both the University CC data and the CMHC data allow for comparison of subgroups. In the CC studies, clients who responded to the follow-up identified themselves by problem type as vocational, academic, or personal. The clients' self-diagnoses of their problems were in the following order:

1976-77 - Vocational 17 (22%), Personal 48 (64%), Educational 11 (14%)

1977-78 - Vocational 23 (22%), Personal 70 (55%), Educational 27 (23%)

The causes for these problems were usually checked as:

N=77, 1976-77--conflict within self 43, lack of information about self 15

N=120, 1977-78--conflict within self 71, lack of information about self 18

Other available but nonsubscribed categories included lack of information about environment, conflict with others, and lack of skill.

Although the order of stated problems is not surprising in this particular setting, the magnitude of differences among the problem areas

of personal, vocational, and educational, gives us some pause. There are several reasons why vocational and educational concerns may appear with less than expected frequency. Most prominent is the existence of a separate Career Services and Placement Center which does some of the vocational counseling. Even so, we have to consider whether there is a subpopulation which we are not now reaching -- those with vocational concerns. Two different questions on the Counseling Evaluation Inventory have also led to significant program questions. These are as shown in Table 3.

Insert Table 3 about here

Two possible explanations are apparent for the downward shift in level of satisfaction, especially in the educational area, from 1976-77 to 1977-78. First, the differential rates of completion, with more push to have all clients receive the client evaluation inventory in 1977-78. In 1976-77 counselors were more likely to selectively pass them out to clients. In 1977-78 standardized procedures were administered to at least ensure students' receipt of them, if not their completion. Perhaps the way counselors handed them out ensured only those who were most satisfied with counseling would receive them. Secondly, the staff of the Counseling Services expanded, with more use of graduate students and

and part-time help in 1977-78 than in the previous year. The graduate students especially were not as well trained or comfortable with academic problems as with other problems which students present. It was also a year of generally rapidly expanding services, which may be responsible for some overall decrease in individual quality.

Specifically, we plan to address at least one of these possible causes by offering to interns preservice and inservice workshops in the area of academic counseling. We will also be looking more closely at whether students presenting with academic concerns are experiencing more distress by the time they reach us than other students, or whether their expectations are different than other students. The response of clients in general to the question, "I liked my counselor as a person," is also less positive in 1977-78 than in 1976-77 (86.6% vs. 96%), but there was no significant trend emphasizing this in any one subpopulation.

Where there was a difference in subpopulations, it was with the educational subpopulation for the question, "Counselor acted uncertain of self."

	1977-78	1976-77
Educational	78% disagree or does not apply	100% disagree or does not apply
Personal	90% "	90% "
Vocational	96% "	100% "

It is this type of information along with counselor reports which enables us to identify areas in need of improvement.

The CMHC data is a much more comprehensive service, allowing for a much broader range of issues to be explored. As noted earlier, the general satisfaction level of the CMHC respondents is not significantly different from that reported in other consumer satisfaction surveys (73%). Nonetheless, we were able to pinpoint problem areas and compare the numbers of respondents who were reportedly concerned about these problem areas and their relationship to the respondents' global satisfaction ratings of the center.

Insert Table 4 about here

Among the findings which had impact on programming was the relationship between educational and economic circumstances of the respondents and the probability that they have received medication as part of their treatment at the center. Although the study doesn't allow for control of sufficient factors to account for this finding, it did lead to useful discussions among the staff about their reasons for the use of medication among the poor or less well-educated clients. It also heightened the general concern of the center staff about those clients who received medication for lengthy periods of time as a primary modality of care.

New formats were devised to more clearly track the medication treatment of individuals, a Coordinator of Medication Service was appointed, and a seminar on use of medications was initiated following this study.

Although there wasn't a one-to-one causal relationship between these new activities and this study, it was one of several influences which led to changes. The staff's input into the design of the study, including areas of questioning about which they were concerned, helped evoke interest in the results. However, there was no organized effort to utilize staff by the administration in follow-up once the results were received. Those staff most interested in different parts of the study did use these data for planning and change. For instance, the results indicated that global dissatisfaction was highest among people who responded that they experienced "rude treatment by staff" (7% of random sample, N = 15), and problems "not taken seriously" (13% of random sample, N = 29). Almost half of these people expressed general dissatisfaction with the center. For interpreting these findings both staff and administrators attempted to identify elements in the service delivery system which would lead consumers to the expression of the specific dissatisfactions mentioned. It was possible to identify particular locations and times in which staff were most likely to be pressed by time and client demands and assume that this would relate to the specific dissatisfactions. Although the staff thought and talked about changes which would alleviate stress for the client and provider, it appeared that the actual data heightened

awareness of the need for change and allowed a more careful focus of staff priorities for change, i.e.,

> "decrease the percentage of clients experiencing rude treatment by staff," and "decrease the percentage of clients who feel their problems are not taken seriously enough."

The data also confirmed both staff and administrators' anecdotal impressions about the parking situation for clients. The staff, however, being more involved in the clinical aspects of service delivery did not focus on this aspect of the service. This "blocking" was aided by the fact that most staff arrived at a time when parking was not a critical problem for them. When nearly a third of all respondents mentioned they either could not find parking or were significantly disturbed by parking problems, this item became more of an issue about which to take action. It prompted center administrators to negotiate for other space adjacent to the center facility. Similarly other areas either increased or decreased in importance, at least in part due to the reaction of consumers in this survey.

Observations and Conclusions

The use of consumer surveys can be a significant tool in the area of program evaluation. In both studies they helped (a) focus staff concern for neglected areas of consumer experience, (b) created a dialogue among staff and administrators for problem identifications and possible options

for problem solution. (This was true for both previously identified and unidentified areas), and (c) provide data for negotiating programs and budget changes with specific target areas for change, e.g., parking, and (d) provide opportunity for programs and services personnel to receive feedback that allowed for personal assessment of service delivery.

This method of client feedback is helpful for program planning and evaluation. However, it is most helpful when

1. data are collected longitudinally to allow for comparisons over time. A baseline for percentage of satisfaction could be established, that would allow for more informed discussion of change in that baseline, for different populations and subpopulations.
2. the value of the data is increased significantly when analyses of data include demographic variables and other critical variables in order to discover who is satisfied and who is dissatisfied with services.
3. variables which describe different environmental program components and refer to different types of acceptability of services will also provide more useful data.

This type of data is also clearly most useful when it can be compared and contrasted to data relating to other outcome dimensions. The need for broad-spectrum program assessment is highlighted by findings which indicate that satisfaction data is not necessarily related to other

behavior change measures (Ciarlo, 1974). Most recently, Hadley and Strupp (1977) have argued for the development of a tripartite model of therapy evaluation including the individual patient, society (including significant others in the patient's life) and the professional. Their arguments for this tripartite model in psychotherapy research are equally valid for the broader area of program evaluation.

A final point is that the ultimate usefulness of this information, its potential for program vitality, review, and change, is tied to the relationships of the evaluator and the administrator, and to the development of mechanisms by the administrator to view this data for program planning. Is the data collected from surveys like these (1) useful?, and (2) utilized? This paper has been an attempt to show how such data can be used and how in some ways it has been utilized. It is the author's intention to have stimulated some thinking about the relationship of one kind of program evaluation and program planning.

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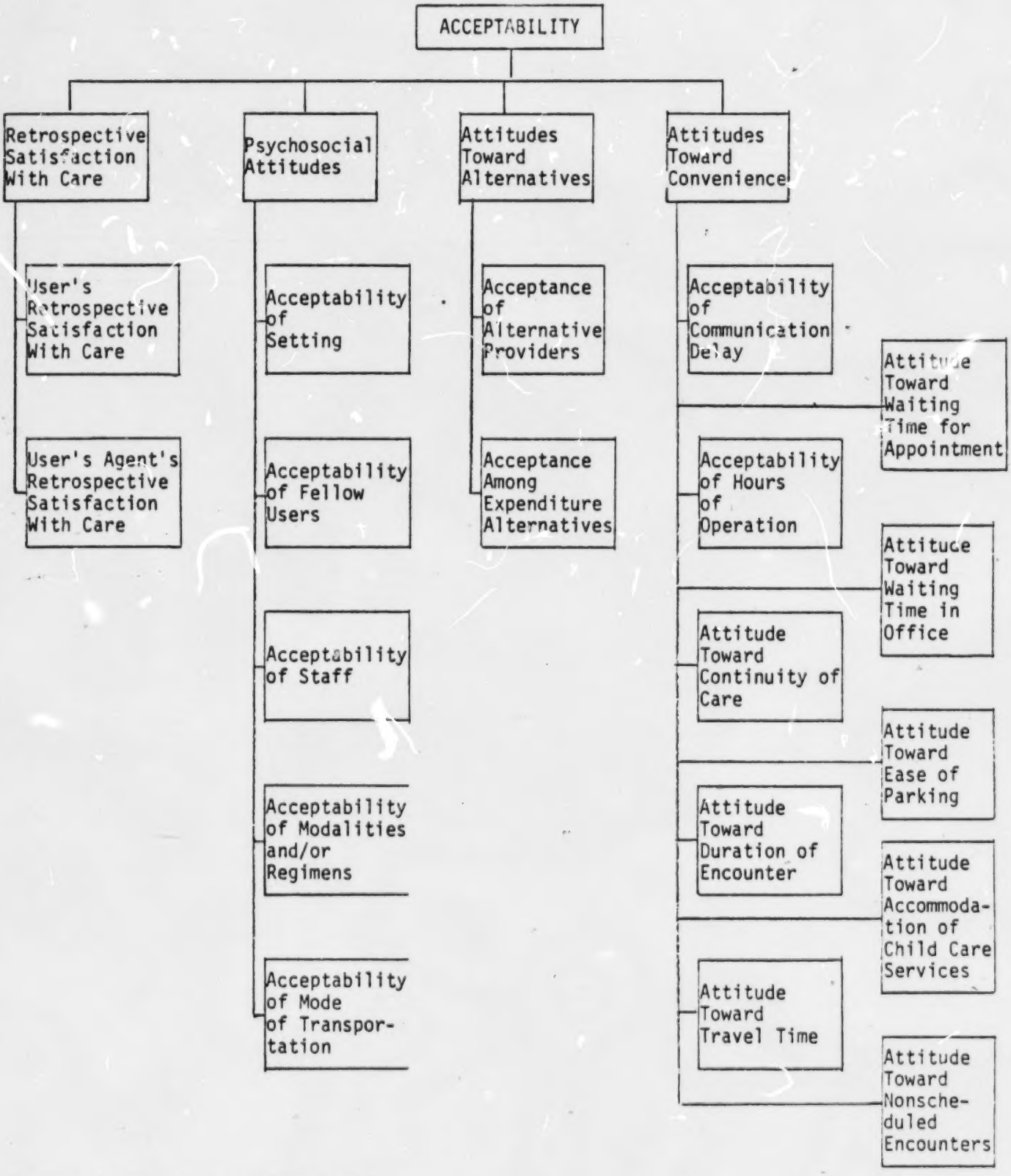
FIGURE 1

Subcategories of Acceptability in Consumer Satisfaction


ACCEPTABILITY
Retrospective Satisfaction With Care
Psychosocial Attitudes
Attitudes Toward Alternatives
Attitudes Toward Convenience
User's Retrospective Satisfaction With Care
User's Agent's Retrospective Satisfaction With Care
Acceptability of Setting
Acceptability of Fellow Users
Acceptability of Staff
Acceptability of Modalities and/or Regimens
Acceptability of Mode of Transportation
Acceptance of Alternative Providers
Acceptance Among Expenditure Alternatives
Acceptability of Communication Delay
Acceptability of Hours of Operation
Attitude Toward Continuity of Care
Attitude Toward Duration of Encounter
Attitude Toward Travel Time
Attitude Toward Waiting Time for Appointment
Attitude Toward Waiting Time in Office
Attitude Toward Ease of Parking
Attitude Toward Accommodation of Child Care Services
Attitude Toward Nonscheduled Encounters

Adapted from Messer and Associates

TABLE 1

Place	Number	Sample of Clients Surveyed	Types of Sampling	Primary Satisfaction Dimensions	Types of Services Evaluated
Rochester Mental Health Center	214	Attempts made to contact random sample of all clients	Personal Interview via telephone Interviewer independent of treatment staff	Global Provider Psychosocial Attitudes toward alternatives Attitudes toward convenience	Clients received individual, group, and medication therapy
University of Rochester	123	Yearly follow-up of clients who received service through Counseling (excluding study skills clients)	Paper and pencil interview via mail	Global Provider Accessibility-Time	Most clients received individual counseling. Most clients made no more than 10 visits.

TABLE 2

A Survey of Selected Consumer Evaluation Studies

Authors/Year	Sample	Interview Mode	Satisfaction Level	Conclusions
Denner and Halperin, 1974	N = 222 - - - - - - - - 25% completion N = 66	Telephone	71% satisfied 47% in between 11% dissatisfied	Client satisfaction not related to problem resolution.
Powell and O'Neal, 1971	N = 209 - - - - - - - - 39% return N = 74	Mail	77% satisfied	Most clients both satisfied and helped by services received.
Heinemann and Yudin, 1974	N = 211 - - - - - - - - 31% return N = 67	Telephone and Mail	92% satisfied	
Heinemann and Yudin, 1974 replication	N = 100 - - - - - - - - 25% return N = 25	Mail	88% satisfied	"response extremely favorable in all areas"
Ciarlo and Reihman, 1974	N = 100	Home Interview	80% satisfied	"client satisfied with services he received"
Denner and Halperin, 1975	N = 247 - - - - - - - - 26% contacted N = 86	Telephone	65% satisfied 17.5% in between 17.5% dissatisfied	Majority of ex-clients are satisfied, and feel the experience has had a global positive effect on their lives. Clients seen for intake and referred out are less satisfied.
Hart and Bassett, 1975	N = 86 - - - - - - - - 63% completion N = 54	Telephone and Home	60% satisfied 31% in between 9% dissatisfied	"first survey so positive. . .we felt it was more of an expression of the patients' reluctance to rate the service"

Denner and Halperin, 1975	N = 247 - - - - - - - - - 26% contacted N = 86	Telephone	65% satisfied 17.5% in between 17.5% dissatisfied	Majority of ex-clients are satisfied, and feel the experience has had a global positive effect on their lives. Clients seen for intake and referred out are less satisfied.
Hart and Bassett, 1975	N = 86 - - - - - - - - - 63% completion N = 54	Telephone and Home	60% satisfied 31% in between 9% dissatisfied	"first survey so positive. . .we felt it was more of an expression of the patients' reluctance to rate the service"
Reinnart and Cazavelan, 1975	N = 386 - - - - - - - - - 37% return N = 134		96% service worthwhile	"clear indication that nine of every ten respondents upheld the clinic's service as worthwhile"
Salasin and Baxter, 1972 (review)	#1 N = 522 #2 N = 127 #3 N = 42 #4 N = 109	Personal Interview	73% satisfied 77% " 83% " 69% "	Most mental health service clients appear very highly satisfied with their treatment.
University of Rochester, 1977-78	N = 120 - - - - - - - - - 66% return N = 80	Mail	87% satisfied	
Rochester Mental Health Center, 1976	N = 250	Telephone	87% satisfied	

TABLE 3

Questions from Counseling Center Inventory

Primary Objective at CC Accomplished:

1976-77

Concerns	Strongly Agree or Agree	Neutral or Disagree
Educational	11 (100%)	0
Personal	37 (77%)	8 (17%)
Vocational	16 (94%)	1 (6%)
1977-78		
Educational	15 (56%)	12 (44%)
Personal	56 (80%)	11 (15%)
Vocational	17 (74%)	4 (16%)

Counseling Experience Was Satisfactory

1976-77

Educational	11 (100%)	0
Personal	43 (89%)	(11%)
Vocational	16 (94%)	1 (6%)
1977-78		
Educational	20 (72%)	7 (28%)
Personal	64 (91%)	6 (9%)
Vocational	21 (91%)	2 (9%)

RMHC STUDY

PATIENT SAMPLE

TABLE 4

FACTORS SHAPING SATISFACTION WITH RMHC

Q. 3a-c:	VERY SATISFIED	SOMEWHAT SATISFIED	NEITHER	SOMEWHAT DISSATISFIED	VERY DISSATISFIED	
ALL RESPONDENTS	77%	13	4	4	3	100%
THOSE DISTURBED BY OVERCROWDING	57%	28	0	5	11	101%
THOSE FEELING FACILITIES ARE UNATTRACTIVE	59%	14	16	0	12	101%
THOSE WHO HAD PROBLEMS WITH PARKING	71%	16	7	5	1	100%
THOSE FEELING CHILDREN'S WAITING INADEQUATE	73%	18	0	9	0	100%
THOSE DISTURBED BY OTHERS IN WAITING/PARKING AREAS	74%	13	4	7	3	100%